

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/25/2013
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NAME OF PROVIDER OR SUPPLIER  KNOX COUNTY ARC	STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE VINCENNES, IN 47591
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W000000	<p>This visit was for the recertification and state licensure survey.</p> <p>Dates of Survey: November 18, 19, 20, 22 and 25, 2013</p> <p>Provider Number: 15G095 Aims Number: 100233980 Facility Number: 000634</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 2, 2013 by Dotty Walton, QIDP.</p>	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, the facility failed for 2 of 4 sampled clients (#1, #3), to ensure the clients' medication, personal space and eyewear training programs were implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation at the group home was done on 11/18/13 from 3:44p.m. to 6:31p.m. Client #3 received his medication at 4:55p.m. Staff #4 punched out client #3's medications. Client #3 was not prompted to assist with the punching out of his medications. Throughout the observation client #1 did not wear his eyeglasses. Client #1 was not prompted to wear his eyeglasses. At 5:18p.m., client #3 put the ear piece of his eyeglasses into his nostril and then pulled it out and began to twirl his eyeglasses in his hand. Staff #5 gave client #3 a verbal prompt to put his eyeglasses on. Staff #5 did not prompt client #3 to clean his eyeglasses.</p>	W000249	<p>W249 Plan of Correction: Staff will be retrained on implementing training objective when the opportunities are present. Staff will be retrained on the importance of continuous active treatment and programming implementation. Preventive Action: Staff will be retrained on implementing training objective when the opportunities are present. Staff will be retrained on the importance of continuous active treatment and programming implementation. Monitoring: Managers will be in the home at least 3xs a week when individuals are present to ensure that all programming needs are being implemented. They will also ensure that active treatment including all objectives is ongoing. Responsible Party: Manager, Assistant Coordinator Date to be completed: December 25, 2013</p>	12/25/2013			

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	<p>At 6:07p.m., client #3 held staff #5's hand and kissed it. Staff #5 did not redirect client #3.</p> <p>The record of client #1 was reviewed on 11/22/13 at 9:34a.m. Client #1's 10/8/13 vision exam indicated client #1 had prescription eyeglasses with an order to "wear full time." Client #1 had a 3/4/13 risk plan for his eyeglasses. The plan indicated client #1 was to wear his eyeglasses during waking hours and to be prompted to wear and to keep them clean.</p> <p>The record of client #3 was reviewed on 11/22/13 at 10:31a.m. Client #3's 8/31/13 individual program plan (IPP) indicated client #3 had the following training programs: medication training program to punch out his medications hand over hand; personal space training to shake hands or high five, no hugs or kisses; eyewear training to clean his eyeglasses.</p> <p>Interview of staff #1 on 11/25/13 at 2:25p.m. indicated client #1's (eyeglasses) and #3's (medication, personal space, eyewear) training programs should have been implemented at all opportunities.</p> <p>9-3-4(a)</p>				

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed for 1 of 4 sampled clients (#4) who received medications, to ensure each client received their medication per the current physician's orders.</p> <p>Findings include:</p> <p>The record of client #4 was reviewed on 11/25/13 at 10:18a.m. Client #4's 11/6/13 "Medication Call Notes" indicated "Risperdal 2 milligrams and Risperdal .5 milligrams at 8p.m., both medications fellout of KCARC's computer program as it was only scheduled a year, [client #4] has not taken since 10/23/13." The physician's orders for 10/13 had indicated client #4 was to receive 2.5 milligrams of Risperdal at 8p.m. for behavioral disturbance. The Physician orders on 11/6/13 indicated to go ahead and restart Risperdal at 1 milligram at 8p.m. On 11/19/13 the physician ordered Risperdal back at 2.5 milligrams at 8p.m.</p> <p>Interview of staff #2 (nurse) on 11/25/13 at 10:05a.m. indicated client #4 did not receive his Risperdal at 8p.m. per physician orders from 10/23/13 through 11/5/13. Staff #2 indicated on 10/23/13</p>	W000368	<p>W368 Plan of Correction: All prescribed medications have been reviewed in the computer program and medications without prescribed stop dates have been updated with a stop date in the year 2063. All newly prescribed medications that do not have a prescribed stop date will automatically have a stop date in the year 2063. Staff will be retrained to notify their supervisor or the on call nurse whenever they see a change in any individuals medications that they do not have an order for.</p> <p>Preventive Action: All prescribed medications have been reviewed in the computer program and medications without prescribed stop dates have been updated with a stop date in the year 2063. All newly prescribed medications that do not have a prescribed stop date will automatically have a stop date in the year 2063. Staff will be retrained to notify their supervisor or the on call nurse whenever they see a change in any individuals medications that they do not have an order for.</p> <p>Monitoring: Managers will be in the homes at least 3xs a week. Nursing services will visit the group home at least 1X a week, and also view all documentation</p>	12/25/2013			

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	<p>the computer generated medication administration record had dropped the 8p.m. dose of Risperdal and no direct care or professional staff had caught this omission until 11/6/13.</p> <p>9-3-6(a)</p>		<p>1x a week. Responsible Party: Managers and Nursing Services Date to be completed: December 25, 2013</p>		

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W000455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation, record review and interview, for 2 of 4 sample clients (#1, #3) and 3 additional clients (#5, #6, #7), the facility failed to encourage the clients to wash their hands before their medication pass and client #6 after sneezing onto his hands while setting the supper table, to prevent the spread of infection.</p> <p>Findings include:</p> <p>An observation was done at the group home on 11/18/13 from 3:44p.m. to 6:31p.m. The following clients came to the medication room and received their medication without washing their hands prior to coming to the medication room and did not wash their hands in the medication room prior to receiving their medication: At 4:04p.m., client #7 came to the medication room and received his medication; at 4:18p.m., client 5 took his medication; at 4:30p.m., client #6 took his medication and was coughing on his hands during the medication pass; at 4:40p.m., client #1 took his medication; at 4:55p.m., client #3 took his medication. Staff #2 and #4 did not prompt the clients to wash their hands. At 4:49p.m., client</p>	W000455	<p>W455 Plan of Correction: All staff will be retrained on the proper way to administer medications. This training will include when to have individuals to wash their hands, especially before a medication pass, and after coughing or sneezing into their hands. Preventive Action: All staff will be retrained on the proper way to administer medications. This training will include when to have individuals to wash their hands, especially before a medication pass, and after coughing or sneezing into their hands. Monitoring: Managers will be in the homes at least 3xs a week. Nursing services will visit the group home at least 1X a week, and also view all documentation 1x a week. Responsible Party: Managers and Nursing Services Date to be completed: December 25, 2013</p>	12/25/2013			

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	<p>#6 received a verbal prompt to set the dining room table with plates for supper. Client #6 did not wash his hands prior to setting the table, he had coughed on them during the medication pass at 4:30p.m. Client #6 coughed on his hands while he was putting plates on the dining room table. Staff in the area did not prompt him to wash his hands.</p> <p>Interview of staff #2 (nurse) on 11/25/13 at 10:05a.m. indicated all clients should be washing their hands prior to receiving their medications. Staff #2 indicated client #6 should have been prompted to wash his hands prior to and as needed during setting the dining room table.</p> <p>9-3-7(a)</p>				